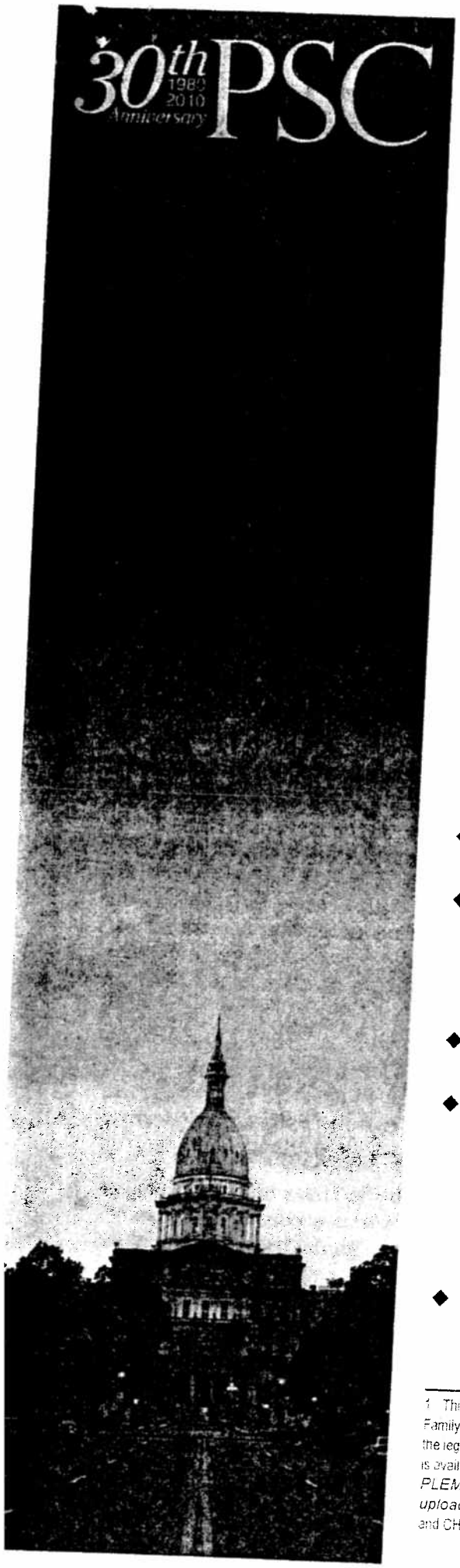

State Implementation of Federal Health Reform

A Timeline[1]

2010

Medicaid and MIChild (CHIP)

- Upon enactment, states are subject to maintenance of effort (MOE) on Medicaid eligibility standards, methodologies, and procedures until an Exchange is operational in the state. States are also subject to MOE for all children in Medicaid and in the Children's Health Insurance Program (SCHIP), until September 30, 2019.
- Upon enactment, states have the option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women.
- Upon enactment, states have a new option to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met.
- Upon enactment, Medicaid is required to cover free standing birth center services (except if state legislation is required).
- As of April 1, 2010, there is a state option to expand Medicaid to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL) through a Medicaid State Plan Amendment and receive current law Federal Medical Assistance Percentage (FMAP) during the period April 1, 2010 to December 31, 2013.
- As of October 1, 2010, states must cover tobacco cessation services for pregnant women enrolled in Medicaid.
- Effective October 1, 2010, states will have new options for offering home and community-based services through a Medicaid State Plan Amendment rather than through a waiver for individuals with incomes up to 300 percent of the maximum SSI payment and a higher level of need. States will also be permitted to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan effective October 1.
- Beginning in 2010 and through 2012, a global payment demonstration project will be established for large safety-net hospital systems in up to 5 states.

---

1 This timeline is a compilation of those prepared by the National Governors Association (NGA) and the Henry J. Kaiser Family Foundation (KFF). KFF has prepared two timelines—one on the overall legislation and the other on the aspects of the legislation that are specific to Medicaid and the Children's Health Insurance Program (CHIP). Each of these timelines is available online. The NGA timeline can be found at *http://www.nga.org/Files/pdf/1003HEALTHSUMMITIMPLEMENTATIONTIMELINE.PDF*. The KFF timelines can be found here *http://www.kff.org/healthreform/upload/80601.pdf* (overall legislation) and here *http://www.kff.org/healthreform/upload/8064.pdf* (Medicaid and CHIP).

Prevention and Wellness

- Beginning in fiscal year 2010 and through fiscal year 2014, HHS will award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.
- In fiscal year 2010, HHS will award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

Workforce

- HHS will establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to as "community health teams") to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to (1) establish health teams to provide support services to primary care providers; and (2) provide capitated payments to primary care providers as determined by the Secretary.

Temporary High-Risk Pool

- Within 90 days of enactment, HHS must establish a temporary high-risk health insurance pool program funded at $5 billion. HHS will work with states to establish a high-risk pool or an alternative program that serves the same purpose. A federal fallback exists if a state chooses not to operate such a program.

Regulation of Insurance

- By July 1, 2010, HHS, in consultation with states, will establish a mechanism, including a website, to facilitate information for consumers and small businesses on coverage options, including public and private options, in each state. Within 60 days of enactment, HHS will develop a standardized format for presenting coverage options.
- Beginning with a 2010 plan year, HHS, in collaboration with states, will review any unreasonable increases in premiums for health insurance. Health insurance issuers will be required to submit to HHS and the state a justification for an unreasonable premium increase prior to the implementation of the increase and will have to post this information on their website. Beginning October 1, 2009 and for a five-year period, HHS will award grants to states to assist them with the review and meeting related standards.
- Within 90 days of enactment, HHS must establish a temporary re-insurance program for reimbursement to participating employment-based plans to cover 80 percent of the cost for claims for retirees ages 55-64, including employees of state and local government.
- Six months after enactment, several new federal insurance rules will take effect, including: a prohibition on insurers from imposing lifetime limits on benefits, restrictions on the use of annual limits, and a prohibition on insurers from rescinding coverage. All health insurance plans will be required to cover recommended preventive services and immunizations. Unmarried children will be able to remain on their parent's health plan until age 26.
- Beginning in 2010 through 2013, employers with fewer than 25 employees will be eligible to receive a federal tax credit to offset 35 percent of their health insurance costs as long as the employer contributes at least half of the premium.
- Aid will be available to states for establishing offices of health insurance consumer assistance or health insurance ombudsman programs to help individuals with the filing of complaints and appeals.
- Within 180 days of enactment, HHS will be required to issue regulations concerning a program that will allow states to apply for a waiver from the individual mandate or certain other requirements of the bill if they can demonstrate that

they have another way of meeting federal coverage requirements. The state waiver program could begin in plan year 2017.

The Exchanges

- HHS is to immediately begin developing standards for establishing and operating state-based Exchanges for individuals and standards for a state-based Small Business Health Options Program (SHOP) Exchange. For a SHOP Exchange, a small employer is defined as having one to 100 employees. Beginning in 2010 and through 2014, federal grants will be available to states for planning and implementation of state-based Exchanges for individuals and small businesses.

2011

Medicaid and MIChild (CHIP)

- States will be required to implement Medicaid fraud, waste, and abuse programs by January 1, 2011 and federal funding for health care fraud and abuse control will be increased by $10 million per year for fiscal year 2011 through 2020.
- Effective January 1, 2011, a new Medicaid state plan option will be created to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. States taking the option will receive 90 percent FMAP for two years for health home related services including care management, care coordination, and health promotion.
- Effective January 1, 2011, procedures, with which states must comply, for screening, oversight, and reporting requirements for providers and suppliers that participate in Medicaid, Medicare, and CHIP will be established; a fee will be imposed on providers and suppliers for screening purposes; and additional billing agents, clearinghouses, and alternative payees will be required to register under Medicaid.
- As of July 1, 2011, federal payments to states for Medicaid services related to health care acquired conditions will be prohibited.
- Effective October 1, 2011, there will be a new state option (Community First Choice Option), which allows states to offer home and community based services rather than institutional care to disabled individuals through Medicaid.
- The State Balancing Incentive Payment Program, which will provide enhanced federal matching payments to increase non-institutionally based long-term care services, will be created in Medicaid on October 1, 2011 and run through September 30, 2015.
- Effective October 1, 2011, new demonstration projects will be created to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition.

Prevention and Wellness

- As of January 1, 2011, $100 million in grant funding will be available to states to carry out initiatives to provide incentives to Medicaid beneficiaries to cease tobacco use, control weight, lower cholesterol, lower blood pressure, and/or avoid or improve management of diabetes.

Workforce

- Beginning with fiscal year 2011 and through fiscal year 2015, funds will be appropriated to build new and expand existing community health centers, and funding will be expanded for scholarships and loan repayments for primary care practitioners working in underserved areas.

2012

Medicaid and MIChild (CHIP)

- By January 1, 2012, HHS is required to establish procedures for determining eligibility for the Community Living Assistance and Supports (CLASS) program, a new national voluntary insurance program for purchasing community living assistance services and supports. By October 1, 2012, HHS must publish regulations concerning the standards for a CLASS Independence Benefit Plan.
- Beginning October 1, 2012, a state's Medicaid Disproportionate Share Hospital (DSH) allotment could be adjusted downward based on significant reductions in the number of uninsured individuals.
- On January 1, 2012, HHS will establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for Medicaid beneficiaries for acute and post-acute care. Grants, which will be given to up to 8 states, will end on December 31, 2016.
- On January 1, 2012, HHS will establish a demonstration project in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings. The demonstration project will end on December 31, 2016.

2013

Medicaid and MIChild (CHIP)

- By January 2013, state Medicaid agencies are required to conduct an assessment of the capacity for entities, such as providers of home care, home health services, etc., to serve as fiscal agents for personal care attendants who provide services to people receiving benefits through the Community Living Assistance Services and Supports (CLASS) Act. States must also designate or create such entities to serve as fiscal agents.
- Authorization and funding for CHIP will be extended through 2015 (two years beyond the current authorization, which is until 2013).
- Funding provided in CHIPRA for Medicaid and CHIP enrollment and renewal activities will be extended and increased from $100 million in 2013 to $140 million in 2015.

Prevention and Wellness

- Effective January 1, 2013, states that cover certain evidence-based preventive services and vaccines with no cost sharing for Medicaid eligible adults will be eligible for a one percentage point increase in their FMAP for such services.

Workforce

- In 2013 and 2014, Medicaid payment rates to primary care physicians for furnishing primary care services are required to be no less than 100 percent of Medicare payments rates. The incremental costs to states of meeting the requirement will be fully funded by the federal government.

The Exchanges

- Prior to January 1, 2013, states will need to notify HHS of their intention to establish and operate a state-based Exchange according to federal standards. HHS will need to make a determination that the state is making sufficient progress toward having the state-run Exchange operational by January 1, 2014. If the state chooses not to establish an Exchange or is not making sufficient progress, HHS will begin to plan for a federally-established/operated Exchange in the state.

Basic Health Plan, CO-OP, Health Care Choice Compacts

- By July 1, 2013, HHS is required to issue regulations for the creation of health care choice compacts whereby two or more states may agree

to allow health insurers to sell products across state lines. Health choice compacts may not take effect prior to January 1, 2016.

- As of July 1, 2013, HHS will appropriate $6 billion to finance the Consumer Operated and Oriented Plan (CO-OP) program and award loans and grants to establish CO-OPs. The CO-OP program is designed to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans.

2014

Medicaid and MIChild (CHIP)

- State Medicaid programs will be required to cover certain non-pregnant, non-elderly individuals with income up to 133% FPL. The cost of services for the expansion population will be fully federally funded in calendar years 2014, 2015, and 2016. States are required to apply a 5 percent income disregard when determining Medicaid eligibility, effectively bringing the new Medicaid minimum eligibility level to 138 percent FPL. States will be required to use modified adjusted gross income to determine eligibility.
- The Medicaid eligibility MOE for non-pregnant, nondisabled adults will expire once HHS has determined a state-based Exchange is fully operational. The bill's provisions call for state Exchanges to be operational by January 1, 2014.
- Concerning enrollment simplification and coordination with state-based Exchanges and CHIP, state Medicaid programs will be required to:
  - Enable individuals to apply or renew Medicaid coverage through a website with electronic signature
  - Establish procedures to enable individuals to apply for Medicaid, CHIP, or the Exchange through a state-run website that must be in operation by January 1, 2014
  - Conduct outreach to enroll vulnerable and underserved populations in Medicaid and CHIP.
- State Medicaid programs will be required to offer premium assistance for employer-sponsored insurance.
- State Medicaid programs will be required to establish procedures to simplify enrollment and coordinate with state-based Exchanges and CHIP. States must implement specific procedures outlined in legislation.
- Beginning in fiscal year 2014, there will be reductions in DSH program funding. The law requires total reductions in DSH funding of $14.1 billion. HHS will develop the methodology for applying the reductions.
- State Medicaid programs will be prohibited from excluding coverage for barbiturates, benzodiazepines, and tobacco cessation products.

Regulation of Insurance

- Beginning with a 2014 plan year, HHS, in conjunction with the states, will monitor premium increases of health insurance coverage offered through a state-based Exchange and outside of an Exchange.
- States will have to establish at least one reinsurance entity for individual and small group markets

The Exchanges

- Launch of the state-based Exchanges for individuals and SHOP Exchanges for small businesses. States may combine these exchanges. The state exchanges will have to comply with certain federal standards and perform functions specified in the statute.

Basic Health Plan, CO-OP, Health Care Choice Compacts

- HHS will have the authority to allow states to establish alternative programs for low-income individuals. Instead of offering coverage through a state-based Exchange, states could negotiate directly with health insurers to establish a basic health program that offers at least one standard health plan providing at least the essential health benefits for certain non-Medicaid eligible individuals with income between 133 and 200 percent FPL.

2015 & Later

Medicaid and MIChild (CHIP)

- Beginning January 1, 2015, state Medicaid programs will be required to begin annual Medicaid enrollment reporting.
- Federal funding for the CHIP program expires September 30, 2015. If a state allotment is insufficient to meet the need, CHIP-eligible children could receive tax credits to obtain coverage through the state-based Exchange. HHS will be required to certify plans in the Exchange that provide comparable benefits for low-income children.
- Beginning October 1, 2015 through September 30, 2019, states will be eligible for a 23 percentage point increase in the regular CHIP match up to 100 percent. This will only take effect if CHIP is reauthorized by the end of fiscal year 2015.
- States will begin to pay a share of the new mandatory Medicaid expansion in 2017.

The Exchanges

- Beginning January 1, 2015, state-based Exchanges must be self-sustaining. Exchanges may charge assessments or user fees.

Basic Health Plan, CO-OP, Health Care Choice Compacts

- Beginning January 1, 2016, health care choice compacts may take effect.
- Beginning January 1, 2017, states that have obtained a waiver from HHS may operate an alternative program in lieu of certain federal health coverage reforms.